Effective Date: October 1, 2006

CRITERIA FOR PRIOR AUTHORIZATION

Insulin-Like Growth Factor

PROVIDER GROUP: Pharmacy

MANUAL GUIDELINES: The following drug(s) requires prior authorization:
Mecasermin Rinfabate (Increlex®) and (Iplex®)

CRITERIA:

Must meet all of the following:

1) Diagnosis of growth failure due to severe primary insulin-like growth factor deficiency (IGFD) or diagnosis of growth hormone gene deletion with neutralizing antibodies to growth hormone.

2) Height standard deviation score less than or equal to -3.0.

3) Basal IGF-1 level below the 2.5 percentile for age and gender as reported by the reference laboratory.

4) Growth hormone levels greater than 25ng/ml documented by response to 2 growth hormone secretagogues.

5) Thyroid and nutritional deficiencies must be corrected before initiating therapy.

6) Patient must be between the ages of 3 and 16 years old with open epiphyses.

7) Treatment must be prescribed and managed by an endocrinologist.

Note: Requests will be denied for use in patients with secondary forms of IGF-1 deficiency, such as GH deficiency, malnutrition, hypothyroidism, or chronic treatment with pharmacologic doses of anti-inflammatory steroids.

Prior Authorization will be approved for six (6) months.

Renewals will be evaluated for approval based on documented improvement per physician assessment.

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Drug Utilization Review Committee Director

Pharmacy Program Manager,
Kansas Health Policy Authority

Date_____ Date_____